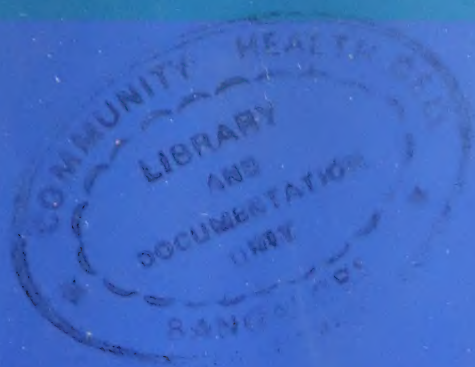


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HIV/AIDS Strategy



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The Department for International Development (DFID) is the UK government department responsible for promoting development and the reduction of poverty. The government elected in May 1997 increased its commitment to development by strengthening the department and increasing its budget.

The central focus of the government's policy, set out in its first White Paper on International Development in 1997, is a commitment to the internationally agreed target to halve the proportion of people living in extreme poverty by 2015, together with the associated targets including basic health care provision and universal access to primary education by the same date. The government's second White Paper on International Development, published in December 2000, reaffirmed this commitment, while focusing specifically on how to manage the process of globalisation to benefit poor people.

DFID seeks to work in partnership with governments which are committed to the international targets, and seeks to work with business, civil society and the research community to encourage progress which will help reduce poverty. We also work with multilateral institutions including the World Bank, United Nations agencies and the European Commission. The bulk of our assistance is concentrated on the poorest countries in Asia and sub-Saharan Africa.

We are also contributing to poverty elimination and sustainable development in middle income countries, and helping the transition countries in Central and Eastern Europe to try to ensure that the widest number of people benefit from the process of change.

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Department for International Development

May 2001

HIV/AIDS Strategy

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Preface

Purpose of the document

This paper provides a strategic framework for DFID staff on how to approach tackling the HIV/AIDS pandemic. It also outlines to a broader readership DFID's priorities and the partnerships we will be pursuing. As such, the paper has specific aims:

- It outlines what we know about HIV/AIDS and key priorities for how DFID should respond at country and international levels.
- It is aimed at all staff and provides a framework for mainstreaming HIV into all DFID's activities.

- It is not an exhaustive list of priorities as these vary from country to country.
- It does not aim to provide detailed information on current technical debates, as these change rapidly and would soon render the paper out of date. DFID will develop regular guidance papers with detailed technical advice on key issues: several will be produced shortly including antiretroviral therapy, maternal to child transmission, vaginal microbicides.

Annex C directs the reader to useful websites and other resources.

1 Introduction

1.1 The challenge to development

1.1.1 In parts of the world HIV/AIDS has become one of the most important challenges to the continued development of many poor countries. AIDS has wiped out four decades of development progress in the hardest hit countries. It is having a disproportionate effect on the poor and is, itself, massively exacerbated by poverty. Unless HIV/AIDS is rapidly and effectively addressed, it will prevent the attainment of the health, education, and poverty reduction International Development Targets.¹ The IDT² for HIV/AIDS is to:

Achieve a 25% reduction in HIV infection rates among 15–24 year olds in worst affected countries by 2005 and globally by 2010.

1.1.2 AIDS not only causes great human suffering but also, in the hardest hit countries, jeopardises economic growth and social and political stability. AIDS in sub-Saharan Africa is shattering families and placing extraordinary burdens on the extended family and village systems that have been the backbone of African child-rearing tradition.

1.1.3 In countries where prevalence is lower, the impact on many highly vulnerable groups will be severe. The levels of infection are currently accelerating in India, south-east Asia, and the Newly Independent States. By 2005, more than 100 million people worldwide will be HIV-positive. Box 1 below shows the impact the epidemic is having. 70% of the burden of AIDS falls on Africa.

1.1.4 The challenge is great. In the absence of an effective vaccine (a vaccine will not be available for some years), responding to HIV/AIDS will require a complex and long term commitment. Responses will vary from country to

country, but the priority will be strategies to promote prevention, whilst reducing the impact of HIV/AIDS. Scaling up the response in the light of weak national capacity will require national, regional and sub-regional action.

1.1.5 The solution to the epidemic lies in the development and implementation of comprehensive national responses, as described below, supported with adequate resources. Where formal systems are overwhelmed by the epidemic, greater importance will be placed on supporting communities to develop their own response, and finding ways to channel resources to them. But as our work in many countries has shown, we can make a difference.

1.2 DFID policy framework

DFID's HIV/AIDS efforts are driven by three overarching policy frameworks:

- The 1997 White Paper: *Eliminating World Poverty: A Challenge for the 21st Century*, committed DFID to focus its efforts to reduce poverty.
- The 2000 White Paper: *Making Globalisation Work for the Poor* identifies tackling HIV/AIDS as a key development issue.
- The DFID Target Strategy Paper: *Better Health of Poor People* identifies HIV/AIDS as one of four key responses that DFID will focus on to improve the health of the poorest. Other strategy papers, notably that on education, stress the importance of HIV/AIDS.

Box 1: Global estimates for the epidemic, end-2000

Epidemiology		Impact
People living with HIV/AIDS	36.1m	Life expectancy reduced by up to 20–30 years
New HIV infections in 2000	5.3m	15.8 million AIDS orphans (30.2 million by 2010)
Deaths due to HIV/AIDS in 2000	3.0m	Negative population growth in 3 African countries
Cumulative deaths due to HIV/AIDS since start of epidemic	21.8m	1–2% loss in GDP per year in hardest hit countries

Source: UNAIDS and WHO, AIDS epidemic update, December 2000

¹Reduce the proportion of people living in extreme poverty in developing countries by at least one half by 2015"

²Established at ICPD +5

2. Understanding HIV/AIDS: risk, vulnerability and impact

2.1 Epidemiological risk

2.1.1 HIV/AIDS has many interconnected causes and consequences. Any strategic response to the epidemic must be rooted in an understanding of why individuals are at risk of infection. The patterns of transmission and the relative importance of underlying factors will vary by country. Box 2 shows the principle means of transmission of the HIV virus.

Box 2: Proportion of HIV transmission globally

%	Means of transmission
80	Sexual transmission (both heterosexual and homosexual)
5	Injecting drug use (sharing needles for injecting drug use)
5	Unsafe blood transfusions
10	Mother to child transmission (occurs <i>in utero</i> , during delivery and through breast-feeding).

Source: USAID

2.1.2 The risk of sexual transmission of HIV is substantially increased by the presence of other sexually transmitted infections (STI), high rates of partner exchange, lack of health information, and the unavailability of condoms. The perception of risk in the future (as with smoking) is low in young people. It is closely related to self esteem. Alcohol is associated with high risk behavior in men. Women’s frequent inability to negotiate sex and the use of condoms is a key factor. Moreover, biologically, women are five times more likely than men to be infected sexually. Women in particular, but also men, who only have one sexual partner are at risk should their partner have multiple other partners. Women with female genital mutilation may be at increased risk of HIV infection.³ Male circumcision is associated with a significant reduction in risk or transmission.⁴

2.1.3 There are two main virus types, HIV-1 and HIV-2. HIV-1 is more easily transmissible than HIV-2 and contributes more heavily to the global pandemic. Ten different HIV-1 virus subtypes (or clades) have been identified as well as five HIV-2 clades. This poses substantial technical problems for vaccine development. The time between infection with HIV and death varies: it

can be more than 10 years, but in developing countries is frequently less. “AIDS” refers to a clinical definition of when an individual’s immune systems have become progressively weak. In developing countries, technology and systems do not exist to monitor population’s immune systems. Anti-retroviral (ARV) therapies can delay the onset of full blown AIDS, but there is not sufficient evidence to show that they can also reduce transmission of HIV.

2.1.4 There is currently no effective vaccine against HIV. The first candidate vaccines are being tested on humans. It is estimated that effective vaccines could become available in about 10 years, and even when available will not be 100% effective, so wider prevention work will still be necessary. There is not yet an effective vaginal microbicide suitable to prevent HIV transmission.⁵

2.2 Vulnerability

2.2.1 Vulnerability to HIV infection and its consequences is determined by a complex set of interactions between a number of key factors. Effective responses depend on these factors being understood and appropriately addressed. Individuals and communities are most at risk when capabilities to avoid infection and deal adequately with its consequences are compromised by inequalities, discrimination, and failures of public policy.

2.2.2 Many factors impact on vulnerability. These include the following:

- Gender inequalities make women and girls particularly vulnerable because they are often compromised in their ability to negotiate safe sex or to ward off unwanted sexual attention.
- The vulnerability of young people is increased significantly if they are deprived of information and reproductive health, education, and other services. The vulnerability of refugees and migrants can be increased by similar factors.
- Discrimination against people living with HIV and AIDS, and those who care for them, multiplies the burden of care on family and friends and excludes infected people from adequate support and treatment.
- Inadequate or inappropriate public information, and the absence of counselling and support services,

³WHO Female Genital Mutilation Information Pack, August 1996

⁴UNAIDS Report on the global HIV/AIDS epidemic, June 2000

⁵A microbicide is a product that can be used vaginally to prevent infection

reduce people's capacities to protect themselves from infection and behave responsibly towards others.

- Fear of stigma and discrimination discourages people from seeking counselling and support where this is available, and increases the likelihood that infection will be passed to others.
- Heavy-handed responses to commercial sex and drug use and to homosexuality, can lead to exclusion from counselling and information and adequate health services, and initiatives such as condom supply and needle exchange programmes, and thus increase the risks of transmission.
- Poverty, insecure livelihoods, and lack of social protection can increase the likelihood of risky behaviour and undermine capacities to cope with the consequences of infection, creating downward spirals in both vulnerabilities to infection and its consequences.

2.2.3 Emergency and conflict situations. Preventing the spread of HIV/AIDS, and coping with its impact is particularly difficult during emergencies and conflict situations. Prevention and care facilities and social networks break down along with social services and infrastructure. Increased population migration, the particular living conditions in refugee camps, and the breakdown of norms and values that govern sexual behaviour can all contribute to increased spread of the virus and the onset of AIDS. Armed forces can show particularly high HIV infection rates compared to civilians and their contact with local populations and the sex industries that tend to grow up around them can increase the spread of HIV.

2.3 Impact of HIV/AIDS epidemic on development

2.3.1 More than 95% of HIV infected people live in the developing world.

2.3.2 HIV/AIDS is reversing life expectancy gains made in the last 40 years. By 2000 life expectancy had declined by 20-30 years in the hardest hit countries. Population structures are also being radically altered. The economically active age group of 15-45 year olds are particularly severely hit. In Botswana in 20 years time there will be more adults in their 60s and 70s than in their 40s and 50s. The epidemic has increased mortality rates and now threatens the child and maternal international development targets. 55% of HIV positive adults in sub-

Saharan Africa are women and at the end of 2000 there were 1.4 million children living with HIV/AIDS.⁶ Women and children also bear a heavy burden of coping with the impact of HIV in families.

2.3.3 There is growing evidence that high HIV prevalence is linked with reduced gross domestic product (GDP). UNAIDS estimate that as HIV prevalence rises to 20% or more, GDP growth may decline by up to 2% per year.⁷ In South Africa HIV/AIDS is projected to reduce the economic growth rate by 0.3 – 0.4% annually, resulting in the GDP in 2010 being 17% lower than it would have been without AIDS. The epidemic contributes to skills shortages in a shrinking labour force, weakens incentives for investment and strains government budgets.⁸ HIV/AIDS reduces the productivity and profitability of businesses and enterprises. Worker absenteeism due to illness and funeral attendance reduces productivity. Employer covered burial and health care costs, increasingly high labour turnover, and increased staff training costs, combine to reduce profitability.

2.3.4 Health and education services. In many countries, especially sub-Saharan Africa, HIV/AIDS is putting an enormous strain on health and education services by drastically reducing the number of staff, the number of new trainees, and the length of service of current staff with HIV/AIDS. The institutional capacity of services is being seriously affected. At the same time the health care sector is overwhelmed with a massive increase in patients (up to 80% of hospital beds being occupied by HIV related illness). In addition there is evidence of declining school attendance rates, in particular of girls, as children assume caring or head of household roles, supporting or replacing parents with HIV/AIDS.

2.3.5 Households and livelihoods. HIV/AIDS has a major impact on the households of people living with the disease. Households are driven to develop short-term coping strategies which tend to have negative long term consequences as, for example, young girls miss school to take on caring responsibilities. HIV/AIDS impacts on the food and livelihood security of households and communities. Households' financial and non-financial assets are threatened by illness and death. Human capital diminishes as people and skills are lost and social networks break down. Physical capital is depleted as farmland becomes poorly managed. As livelihoods are threatened and productivity undermined, nutrition and health declines.

⁶UNAIDS and WHO, AIDS epidemic update, December 2000

⁷UNAIDS and WHO, AIDS epidemic update, December 2000

⁸UNAIDS, The Global Business Council on HIV/AIDS and the Prince of Wales Business Leader Forum, The Business Response to HIV/AIDS: Impact and Lessons learned, UNAIDS, 2000

2.3.6 In rural settings, poor people's vulnerability will depend on their wider capacity to manage the impact of HIV/AIDS on the household. This will be dependent not only on labour, physical and non-physical assets and markets, but also on mitigating the stigma that HIV imposes in such communities.

2.3.7 Security. In 2000, the UN Security Council acknowledged HIV/AIDS as a global security risk as well as

a human security issue. The high attrition caused by AIDS deaths in the armed forces and police of many sub-Saharan African countries risks exacerbating instability. The spread of HIV can increase as armies with high HIV prevalence are involved in peacekeeping activities in other countries. And, high HIV prevalence and the subsequent socio-economic impact on societies can be politically destabilising.

3. Tackling HIV/AIDS: what works

3.1 HIV/AIDS: a complex disease

3.1.1 HIV/AIDS is a communicable disease driven by the behaviour of individuals. **As a result, no one intervention is the key to success.** We have learnt much about what needs to be done to tackle the epidemic (see Box 3).

Box 3: Important elements in tackling HIV/AIDS

- Political commitment and leadership at all levels;
- Sustained effort over a long period of time;
- Effective global and national surveillance;
- National resource mobilisation – Uganda: \$2 per capita/year from the national budget;
- National capacity building across all sectors for a broad based response;
- Policies and programmes which tackle the locally specific epidemic;
- Early action in low prevalence countries;
- Mobilisation of civil society, private sector and faith based organisations;
- Willingness to deal with stigma and discrimination.

3.1.2 Not all of these elements have always been in place, but the key message is clear: with a combination of these it is possible to tackle HIV/AIDS. Thailand has done just that with strong government support, resources and focused interventions (the “100% Condom Programme”).⁹

3.1.3 Some countries have successfully reduced the rate of new HIV cases or maintained low levels of prevalence over time either by preventing a major epidemic (Senegal with STI control, Thailand with condoms) or by reducing an existing severe epidemic (Uganda, Thailand, Zambia, Dominican Republic). Prevention alone cannot succeed. Incorporation of a **prevention to care continuum** is required to ensure that persons living with HIV/AIDS receive appropriate care. These individuals, in turn, often become the best change agents for prevention.

3.2 Preventing transmission: reducing the risk of infection

3.2.1 There are a limited number of interventions that can reduce sexual transmission of HIV (see Box 4). STD treatment, condoms, and voluntary counselling and testing (VCT) are effective, particularly when targeted to high HIV prevalent populations (as in Thailand) and to couples. VCT is even more effective when linked to care and support services.

Box 4: Interventions that work to prevent sexual transmission

- *Male and female condoms* are the only reliable barrier method.
- *Combinations of strategies to deliver condoms* are necessary to cover areas of wide geographical and socio-economic diversity, including free and subsidised provision through health services and social marketing.
- *Behaviour change programmes* are an essential and effective part of strategies to reduce high-risk behaviour.
- *Voluntary Counselling and Testing (VCT) for HIV* is vital to enable people to make decisions about their behaviour based upon accurate knowledge of their, or their sexual partners, HIV status.
- *Improved diagnosis and management of other STIs* reduces the risk of HIV transmission.

3.2.2 Injecting drug use. An open and tolerant legislative regime that works with drug users helps reduce HIV transmission through injecting drug use. Programmes can include needle exchange provision, methadone treatment facilities, information and education campaigns that promote needle and syringe disinfecting techniques and reduce sharing of needles. Attempts to change sexual risk behaviour of injecting drug users have been less successful.

3.2.3 Blood safety. Ensuring the safety of blood transfusions and blood products in developing countries reduces HIV and other blood born infections (Hepatitis, Malaria) and increases confidence in health services.¹⁰ Interventions that can improve the safety of blood include

⁹UNAIDS, Relationships of HIV and STD declines in Thailand to behavioural change, 1998.

¹⁰World Bank and European Commission, Confronting AIDS: Evidence from the developing world, 1998.

selective recruitment of voluntary blood donors (such as focusing on youth), screening of blood donations and substituting the use of blood with alternative methods.

3.2.4 Mother to child transmission (MTCT). Approximately a third of infants born to mothers with HIV are HIV positive. ARV reduces the risk of mother to child transmission by up to 50%. WHO recommends the provision of nevirapine; a low cost ARV, to reduce MTCT. DFID agrees, but is concerned about (i) the inability of many health systems to provide VCT (a prerequisite for implementation) and (ii) the cost-effectiveness and opportunity costs relative to other health care priorities. There are complex issues surrounding MTCT involving infant feeding, treatment for the mother, and health system support needs. **A detailed guidance note covering MTCT issues will follow shortly.** See Annex A for fuller description of the issues.

3.3 Reducing vulnerability

3.3.1 The key to reducing vulnerability is to create an environment that enables people, both women and men, to access and use the interventions outlined above. To achieve this requires strong and sustained political commitment. Government and civil society need to open out the public discussion about HIV/AIDS, sex, and gender relations and promote openness and respect for the human rights of all people. Explicit commitment to tackling stigma and discrimination is essential. Participatory models can help identify how best to support the most vulnerable, and develop strategies to provide them with the information they need.

3.3.2 The societies which have been most successful in facing the challenge of HIV/AIDS have been those in which it has been faced openly, and where communities of support have been built for, and by, those at risk and those affected. Strong leadership is required to bring the debate about HIV/AIDS out into the open, and to create a supportive policy and legal framework and to challenge social norms which increase vulnerability. Civil society must embrace people living with HIV and AIDS and create an atmosphere of active support and social inclusion. The rights of all people to control their own sex lives and demand safe sex must be actively upheld. Information about all aspects of HIV/AIDS must be freely and widely available, and public debate stimulated and encouraged and led from the highest levels.

3.3.3 Mass media campaigns, using appropriate communication strategies and locally appropriate idioms, are an essential element. Top-down information campaigns are rarely as effective as more inter-active media such as soap opera and theatre, where complex issues and

differing views and perspectives can be fully explored and public debate encouraged. Peer-based support and dialogue, among youth and other at-risk groups including long distance transport workers, is also important.

3.3.4 Effective education programmes raise awareness of actual risk of infection. Ensuring people's rights to information and training programmes helps women and girls negotiate condom use with sexual partners and to delay their first sexual contact. Behaviour change, and other communication programmes, supported by a positive policy environment, can be an effective part of HIV control strategies and should be properly integrated into national HIV/AIDS control programmes. They need a coordinated approach to communications involving government, local and national media and civil society. Box 5 below asks what we can do in the education sector.

Box 5: What can we do in the education sector?

HIV/AIDS is causing unprecedented human resource loss in education systems. Ministries of Education and Labour need to develop and implement strategies to prevent severe skill shortages in both the public and private sector. This can include investigating new pathways into education, distance learning methodologies, access to training and education and in the longer term the expansion of training facilities and their throughput.

Education helps prevent the spread of HIV and build a society which reduces stigma and accepts persons living with HIV/AIDS (PLWHA).

Education plays an important role in achieving difficult changes in societal norms. Focusing on children and youth is an effective part of this.

The young, especially pre-sexually active youth and children, are more open to behavioural change initiatives. Young people, females in particular, are particularly vulnerable.

3.3.5 Social protection of the most vulnerable, especially women and children, helps give them more control over their lives, and reduces their vulnerability, for example by ensuring that children are not forced into unequal sexual relations with adults. Access to wider economic opportunities can reduce the vulnerability of poor people to exploitation, and reduce vulnerability to risky behaviour. In some cases, income generating schemes and wider livelihood opportunities can provide alternatives to commercial sex work.

3.3.6 We have a lot to learn from existing reproductive health programmes. Long term commitment from government and the international community is essential. In Bangladesh, a remarkable success story, it took 15 years of sustained political and donor commitment to develop an open family planning programme leading to more than 50% of couples currently using effective family planning methods.

3.4 Treatment and care

3.4.1 The long term development of stronger, pro-poor, sustainable health systems is essential to ensuring the safe delivery of treatment and care for HIV/AIDS. Services for addressing HIV/AIDS need to be fully integrated into health services as they strengthen and extend their coverage. Treatment involves clinical interventions ranging from addressing opportunistic infections such as TB to provision of ARV therapy. *With 40% of AIDS deaths due to TB, treatment can have significant effects on length and quality of life.*

3.4.2 The ultimate aim is to maintain the best possible quality of life for as long as possible for persons living with HIV/AIDS without bankrupting the family. Developing a prevention-care continuum, which maximises community and home-based care and treatment improves the quality of life of PLWHA and reduces the burden on their families. Counselling for individuals and families is an essential part of any minimum package of care. Many families of PLWHA, as with all marginal and vulnerable groups, need support to ensure food security and good shelter while coping as part of broader strategies to ensure their livelihoods.

Box 6: Antiretrovirals (ARV)

DFID works to improve the health of poor people by contributing to the long term development of strong, efficient and effective health systems that respond to their needs. A central element in these partnerships is to support efforts to combat HIV/AIDS through the most cost-effective, feasible and proven measures. Prevention remains the priority.

Antiretrovirals are becoming less expensive, offering hope to many people, but they are still unaffordable to most poor people. There are significant equity, cost and sustainability issues. ARVs must be taken for life and are highly toxic drugs. Even if they were free, it is not feasible for health systems in many poor countries to deliver these drugs safely and equitably. Until safe and equitable systems can be put in place it would be inappropriate to use scarce resources to support wide-scale provision of ARVs for treatment.

DFID is currently supporting work on feasible policy options for the use of antiretroviral therapy to help governments make informed decisions about their use that is specific to local needs and circumstances. There is an urgent need to test simpler treatment regimens than the current western systems. Whilst this raises ethical issues, such regimens offer the prospect of prolonged quality of life to those that might otherwise have no access to ART.

DFID is developing separate guidance notes on HIV/AIDS treatment and care, including ART and Prevention of Maternal to Child Transmission.

3.5 Epidemiological surveillance/ monitoring and evaluation

3.5.1 Trends in the epidemic vary between countries as does the profile of those infected. In Russia HIV transmission is mostly due to injecting drug use and is high amongst commercial sex workers. In Africa hetero-sexual transmission is the predominant mode. Epidemiological data on key modes of transmission is necessary to guide the response to the epidemic and evaluate effectiveness of interventions. In particular the possible spread of transmission from high risk behaviour to the general population needs monitoring.

3.5.2 Thailand demonstrates the vital importance of high quality epidemiological data to effectively guide policy to address the predominant mode of transmission.

Worldwide, better data is required to measure the effectiveness of HIV/AIDS control programmes and their contribution towards the decline in new infection. It is important to distinguish whether plateaus in new cases are a result of successful control campaigns or because of natural containment of the epidemic among high-risk behaviour groups only.

3.6 Impact mitigation

3.6.1 Strategies to reduce the impact of the epidemic can be targeted at individuals or across society. In many countries, the large number of orphans surviving the epidemic requires a concerted response, which aims to give them the best possible livelihood opportunities. Fostering is important but care is needed to ensure so far as possible that the children receive the same education, nutrition, and opportunities as children not orphaned by AIDS. Community-based care is the only affordable care in most settings. Strategies to reduce impact should also address livelihood protection for households affected by AIDS related illness and death. These interventions may include micro-credits for people living with HIV/AIDS to help them sustain a livelihood.

3.6.2 The importance of education for development and health, in particular of female education, is so great that the current threat to the education of children resulting from HIV/AIDS in many countries needs to be urgently addressed. Education is key to reducing impact, reducing

future vulnerability, and ensuring that future renewal of skilled labour force occurs.

3.6.3 It is essential for all sectors of society and the economy to plan for a future with a drastically reduced skilled and un-skilled labour force. Education, health, police, military, law enforcement, business and industry are already suffering from loss of skilled labour, the costs of recruiting and training new staff, and the cost of caring for current staff with HIV/AIDS.

3.6.4 Some companies have introduced employment-based health insurance to protect against the risk of infection, sexual health services (including for sex workers near major enterprises with residential workforces), and provision of care and counselling. Some large companies in West Africa even provide ARVs, judging that their provision outweighs the costs of loss of skilled staff.

3.7 Building knowledge

3.7.1 There is considerable ongoing research into the impact of HIV/AIDS, the effects of policy responses, effective approaches to HIV/AIDS prevention and on new technologies to prevent HIV transmission and treat HIV/AIDS. Vaccine research needs to focus on the clades that are most prevalent in developing countries, as immune response may be clade specific. The potential of vaginal microbicides as a female controlled means to prevention requires considerable attention. More behavioural research is needed.

4. What needs to be done

4.1 In countries

4.1.1 The fight against HIV/AIDS can only be won at the country level and with national leadership. Civil society also provides valuable leadership, both with government and in many countries where government has not yet responded to the epidemic. The variability in prevalence of the epidemic requires governments to develop different strategies, even within the same country. A range of activities can be recommended for the different stages of the epidemic which countries or provinces can undertake. For the purposes of this document we consider that countries have¹¹:

- low prevalence/nascent epidemics where even in accepted risk populations¹² there is a <5% prevalence;
- concentrated epidemics, where the overall prevalence is low but where certain risk populations have >5% prevalence rates (e.g. 80% in some populations like sex workers in China);
- generalised epidemics where the infection is >1% in women attending ante-natal clinics.

(Annex B presents a matrix, grouping different packages of interventions for each level of transmission). Key elements of a successful national response are outlined in Box 7.

Box 7: Key elements of successful national response

- HIV/AIDS fully recognised and addressed within HIPC, PRSP, UNDAF and SWAP processes, and national responses are multi-sectoral and are sustainably embedded with the national budget.
- All sectors plan to reduce the impact of the epidemic.
- Addressing the underlying causes of vulnerability, in particular human rights, stigma, discrimination and gender inequalities.
- Support is provided to ensure that the education system is suitably harnessed to address HIV/AIDS prevention and manage the impact of AIDS on schools and educational institutions.
- Support, including resources, through the public and private sector is provided to ensure that condoms are fully accessible.

- Working with civil society and NGOs to maximise their contribution.
- Capacity is built to enable countries to deliver high quality prevention, treatment and care for PLWHA. This will require substantially strengthened health systems.
- Monitoring and surveillance systems are developed to measure effectiveness and guide priority setting.

4.2 International partnerships: UN agencies, multilateral development banks

4.2.1 International agencies have important roles to play in generating global political commitment and supporting effective, co-ordinated action at country level. UNAIDS¹³ has an important role in advocacy, resource mobilisation and providing global leadership. The United Nations General Assembly Special Session on HIV/AIDS in June 2001 should catalyse an intensified international effort to provide better support for countries to effectively fight HIV/AIDS.

4.2.2 WHO has a key role as the global normative technical agency. It needs to improve its own support to countries and increase its capacity to address HIV/AIDS. Other UNAIDS cosponsors also have important global responsibilities: UNICEF on MTCT and education issues, UNFPA on ensuring long-term global contraceptive security, and the World Bank on resource mobilisation, policy dialogue and programme implementation with countries.

4.3 Civil society organisations

4.3.1 Civil society and in particular non-governmental organisations (NGOs) play a vital role in combating HIV/AIDS. Their strengths include advocating on behalf of PLWHA, addressing stigma, creating an environment of openness, advocating human rights, and in particular tackling gender inequalities. Civil society organisations are most able to work with vulnerable groups, with NGOs providing prevention and care for high-risk groups including men who have sex with men and sex workers. NGOs have a role in care and treatment for PLWHA and in voluntary counselling and testing.

¹¹UNAIDS/EHI/USAID, Meeting the behaviour data collection needs of national HIV/STD programmes, May 1998.

¹²Guidelines for second generation HIV Surveillance, www.unaids.org/publications/documents/epidemiology/surveillance, 2000

¹³UNAIDS is the joint UN Programme for HIV/AIDS.

5. DFID's response

5.1 Six overall responses

5.1.1 To date DFID has supported strong and substantial bilateral programmes, worked with international agencies and supported research on a range of issues. Our support has become increasingly multi-sectoral, particularly with health and education working more closely on comprehensive HIV/AIDS strategies. We will build on this. DFID is committed to achieving the global HIV/AIDS international development target, and in particular, to reducing the impact that HIV/AIDS has on the lives of the poorest. Building on its experience DFID has identified a set of principles which underpin its HIV/AIDS strategy.

Box 7 Principles underpinning DFID's response to the HIV/AIDS epidemic

- Involve and support people living with HIV/AIDS (PLWHA) to the maximum extent possible in programmes that address their needs.
- Ensure country ownership and leadership of programmes, working with civil society, to maximise responsiveness to country needs.
- Support for tackling HIV/AIDS must ensure that the needs of the poorest are met.
- Address the gender inequalities which fuel the epidemic.
- Emphasise support for national expertise and institutions in implementing programmes.

5.1.2 Tackling HIV/AIDS requires a global partnership. DFID will not work in isolation, but will develop partnerships with a wide range of actors to address HIV/AIDS and achieve the international development target. Six overall responses constitute DFID's contribution to the fight against HIV/AIDS:

Response 1: Build political leadership

International political commitment to tackle HIV/AIDS is now substantial, but this commitment needs to be sustained and translated into effective national political commitment and action. Efforts must now be focused on national leadership. We will work with governments to develop, implement and monitor effective national inter-sectoral HIV/AIDS plans to tackle the epidemic.

Response 2: Building national capacity

To address HIV/AIDS will require a prolonged and sustained effort to build the institutional capacity that is required across all sectors.

Response 3: Tackle the underlying causes of vulnerability

Successfully responding to the epidemic requires open debate addressing stigma, gender inequalities, and poverty. This will require a strong focus on the rights of women and men, children and persons living with HIV/AIDS.

Response 4: Maximising the contribution of all sectors

We must ensure that the global and national response to HIV/AIDS harnesses all sectors. In particular we will work to improve the linkages between strong, equitable health systems, education and livelihood sectors. A key focus will be on addressing and developing innovative strategies to tackle the human resource attrition due to AIDS.

Response 5: Prevention to care continuum

In the absence of a vaccine or cure, DFID will support comprehensive HIV/AIDS prevention and care programs, as outlined in this paper. Care is about effective health systems, and supporting families and communities to manage the impact of the epidemic in open and supportive environments. We will work with community based programmes, civil society, and public and private sectors.

Response 6: Supporting the development of knowledge generation

We will continue to support research and incentives into new drugs and vaccines and strategies for their delivery. We will also support work to evaluate and monitor the impact of multi-sectoral strategies to tackle the epidemic.

5.2 Partnerships

5.2.1 We will take forward this response in partnerships with countries, international agencies, civil society and the private sector. In particular we will work with developing country governments to help them develop and implement sustainable programmes to control HIV/AIDS. We will continue to work to help governments maximise the contribution of all sectors, including the private sector, towards AIDS control.

5.2.2 DFID will continue to work with UNAIDS cosponsors and other UN agencies to improve the quality and appropriateness of technical guidance and support for developing countries. We will continue to challenge the UN agencies and multilateral development banks to improve their coordination, in particular at country level through the UN Theme Groups. We will work with UNAIDS to improve its performance (see Box 8) and will contribute to the evaluation of UNAIDS to ensure it learns from its first five years.

Box 8: Working with the UNAIDS programme

Working with UNAIDS, DFID aims to:

- Improve co-ordination between UNAIDS cosponsors and other donors to provide better support to countries.
- Build capacity within UNAIDS cosponsors to address HIV/AIDS, in particular through improved mainstreaming and improved engagement with SWAP and PRSP processes.
- Generate and collect better data to track the epidemic and highlight what is effective in tackling it.
- Ensure that countries are supported in appropriately locating national HIV/AIDS responses within the PRSP, UNDAF, SWAP and HIPC processes.
- Better promote evidence-based, effective and proven strategies and interventions.

5.2.3 DFID will continue to work with other donors to ensure a sustained and incremental increase in the resources committed to tackling HIV/AIDS, as well as co-ordinated scaling up efforts. At present the global resources committed to tackling HIV/AIDS are woefully inadequate. We will encourage the EC to find more effective instruments for it to provide support to countries in their efforts to tackle HIV/AIDS. In Africa we will continue to work to improve the effectiveness of the International Partnership against Aids in Africa (IPAA) and World Bank regional work to support effective AIDS control programmes. DFID will work with civil society and NGOs to maximise their strengths.

5.3 Developing new knowledge and technologies

5.3.1 We will work with other donors, WHO, UNAIDS and the EC, through a range of international fora, including G8 and UN, to improve the affordability of current and future drugs and other technologies for preventing HIV transmission and caring for PLWHA. We will support on-going dialogue with the pharmaceutical industry to increase the affordability of currently available drugs including ARV through a range of measures including tiered pricing.

5.3.2 DFID will continue support for the development of affordable and effective HIV vaccines for developing countries. In addition to continued support for the International AIDS Vaccine Initiative (IAVI) we will work with other UK government departments and the EC to improve the framework for encouraging investment in research and development for vaccines and drugs to treat HIV/AIDS. DFID will continue to support investment in other new technologies to prevent HIV, including microbicide research.

5.3.3 DFID supports knowledge generation programmes that focus on HIV/AIDS, reproductive health and health systems development. In addition to these we will continue to commission strategic research on key issues to inform policy or best practice, including the impact of multi-sectoral strategies and behaviour change interventions to tackle the epidemic. First priority is an analysis of the economic and social consequences of providing ARV in resource poor environments to prevent MTCT and to delay onset of AIDS.

6. Within DFID

6.1.1 To implement this strategy DFID will need to improve and adapt its own institutional capacity to tackle HIV/AIDS. A key element will be to continue to raise awareness among staff of HIV/AIDS issues, including their own vulnerability to HIV. This will be integrated into the induction programmes of new staff. Further focused training programmes are being developed to help staff increase knowledge of the social and economic impact of HIV/AIDS, evaluating strategies for preventing transmission and strategies for reducing vulnerability.

6.1.2 DFID's own policy on staff with progressive illness, currently under development, will need to be consistent with the standards that the international community promotes for employers in developing countries. DFID will also need to develop a coherent policy for provision of care and support to staff with HIV/AIDS and their families. DFID will coordinate with the FCO and DOH.

6.1.3 Many lessons can be learned from DFID offices in Africa who are most advanced in their multi-sectoral response to HIV/AIDS. We will need improved communications between departments to better disseminate lessons learned, best practice, and updated information. The Internet website will be expanded to

provide ready access to up to date technical guidance and lessons learned from programmes. Links to key partners websites will be regularly updated. DFID's internal inter-departmental HIV/AIDS working group will take more responsibility in managing the lesson learning and knowledge flow throughout the department. Similarly, DFID will work with other UK government departments to ensure a consistent UK government approach.

6.1.4 This strategic outline highlights a number of areas where further research is required. DFID will follow up this paper with a series of more detailed technical guidance notes on key issues facing staff working on programmes to tackle HIV/AIDS. Initial papers to be published in the next year include guidance notes on:

- preventing MTCT;
- the provision of ARV;
- education and HIV;
- vulnerability reduction strategies which tackle gender inequalities;
- HIV and sustainable livelihoods;
- communications and HIV; and
- success stories in HIV.

7. Measuring the effectiveness of the DFID response

7.1.1 The effectiveness of DFID's response to HIV/AIDS will be measured by the achievement of a range of IDTs on poverty reduction, health and education. DFID's support will be measured by the effectiveness of country responses to HIV/AIDS. DFID will also measure its performance against the PSA and SDA and the responses outlined above.

7.1.2 DFID will continue to work with governments, WHO and UNAIDS to improve monitoring and evaluation of all aspects of the response.

7.1.3 The total cost of tackling HIV/AIDS globally is considerable. DFID funding for HIV/AIDS control programmes will continue to increase. As we move to a more integrated response, tracking and attributing HIV specific spending will become increasingly difficult and meaningless. However DFID will continue to increase support for mainstreaming HIV/AIDS within the context of overall development needs.

Annex A: Cutting edge issues in HIV/AIDS

Preventing mother to child transmission

A short course of ARV (consisting of two doses of nevirapine – one just before delivery and one to the new born child) reduces the risk of mother to child transmission of HIV by up to 50%. WHO/UNAIDS consider the use of ARVs to prevent MTCT to be safe and effective enough to warrant their use beyond pilot projects and research settings.¹⁴ DFID agrees, but is concerned about (i) the inability of many health systems to provide VCT (a prerequisite for implementation) and (ii) the cost-effectiveness and opportunity costs relative to other health care priorities. The risk of MTCT through breastfeeding can be reduced by completely replacing breast milk with a substitute such as infant formula. However, there is evidence to suggest that exclusive breast feeding is no more risky than exclusive replacement feeding, and that the highest risk of MTCT is associated with mixed feeding (both breast milk and other). The use of ARV for the sole purpose of preventing MTCT is criticised by some because it does not benefit the health of the mother. The children of HIV positive mothers inevitably become orphans, but uninfected orphans are less of a burden to communities than HIV positive orphans. A key issue for both ARV and infant feeding is that the mother is supported in making an informed choice. A DFID virtual team is developing a fuller guidance note covering the whole range of MTCT issues.

Cotrimoxazole

The long term development of stronger, pro-poor, sustainable health systems is essential to ensuring the safe delivery of treatment and care for HIV/AIDS. Services for addressing HIV/AIDS need to be fully integrated into health services as they strengthen and extend their coverage. The latest evidence suggests that, with the exception of TB treatment, the treatment of opportunistic infections does not add significantly to the length of life, but does help improve the quality of life. The provision of cotrimoxazole for PLWHA as prophylaxis against secondary infections is recommended by the WHO and UNAIDS. DFID has concluded that at present there is insufficient evidence to support the WHO/UNAIDS recommendation because of the extent to which it is possible to draw meaningful conclusions from existing trials, the very real danger of increased resistance resulting from widespread use, the lack of trials on children and the lack of research on the implications for the treatment of malaria. DFID is supporting ongoing research to increase the evidence on the use of cotrimoxazole prophylaxis. Additional research is ongoing to assess the potential role of different means of preventing TB in HIV positive people.

¹⁴UNAIDS/WHO Press Release: Preventing Mother to Child HIV Transmission, October 2000.

Annex B: Matrix showing strategies for different epidemics*

(see paragraph 4.1.1.)

	Concentrated epidemic	Generalised epidemic	Generalised epidemic
Intervention Targeting Approach	Targeting to most vulnerable groups (e.g., CSW, IDUs, MSM, transport workers and migrant workers) and their partners	Targeting to most vulnerable groups and their partners	Targeting to most vulnerable groups and their partners and to general population
Prevention Strategies	<ul style="list-style-type: none"> ● Political leadership mobilisation ● Stigma reduction ● Functional national HIV strategy in place ● Effective surveillance system in operation ● Data about activities/epidemic collated and available ● Population aware of STIs and HIV and how to avoid them, especially sub-populations with high incidences ● Condoms available, affordable and accessible ● Blood screening ● HIV and sexual health integrated into school curricula ● Operations research to understand transmission patterns and impact of interventions ● STI treatments and diagnosis available and accessible for women and men ● Private sector involved through social marketing ● Infection Prevention and Quality Assurance guidelines in place and observed ● Capacity building of NGOs ● All DFID projects to assess impact of HIV 	<p>Same package as low prevalence/nascent, with:</p> <ul style="list-style-type: none"> ● Effective outreach for at risk sub-populations. ● All DFID projects to include HIV/AIDS considerations and/or prevention interventions. ● Expanded training of health care workers 	<p>Same package as concentrated epidemic with:</p> <ul style="list-style-type: none"> ● Expanded commodity security and distribution ● Expanded involvement of youth ● IEC campaign to address national epidemic
Care Strategies	<ul style="list-style-type: none"> ● Planning for VCT ● Basic health care delivery for OIs 	<p>Same package as low prevalence/nascent, with:</p> <ul style="list-style-type: none"> ● Implementation of VCT ● Health systems development to support care ● Expanded training of health care workers 	<p>Same package as concentrated epidemic, with:</p> <ul style="list-style-type: none"> ● Voluntary testing and counselling ● Syndromic treatment and diagnosis of STIs ● Antiretrovirals for pregnant women ● Effective care and support strategies ● Health systems development to support care
Mitigation Strategies	<ul style="list-style-type: none"> ● None 	<ul style="list-style-type: none"> ● Planning for expanded social service delivery ● Economic impact of HIV/AIDS assessment ● Planning for the impact of HIV/AIDS on all sectors 	<p>Same package as concentrated epidemic, with:</p> <ul style="list-style-type: none"> ● Interventions to care for increased number of orphans ● Expanded business and labour sector involvement ● Active multisectoral involvement ● Increased legal protections ● Coping strategies for families and communities

* Based on matrix developed by Kate Butcher, JSI (UK)

Annex C: Additional resources and further reading

Useful Websites

UNAIDS	www.unaids.org
Family Health International	www.fhi.org
International AIDS Economic Network	www.iaen.org
World Bank	www.worldbank.org
Unicef	www.unicef.org

Further reading

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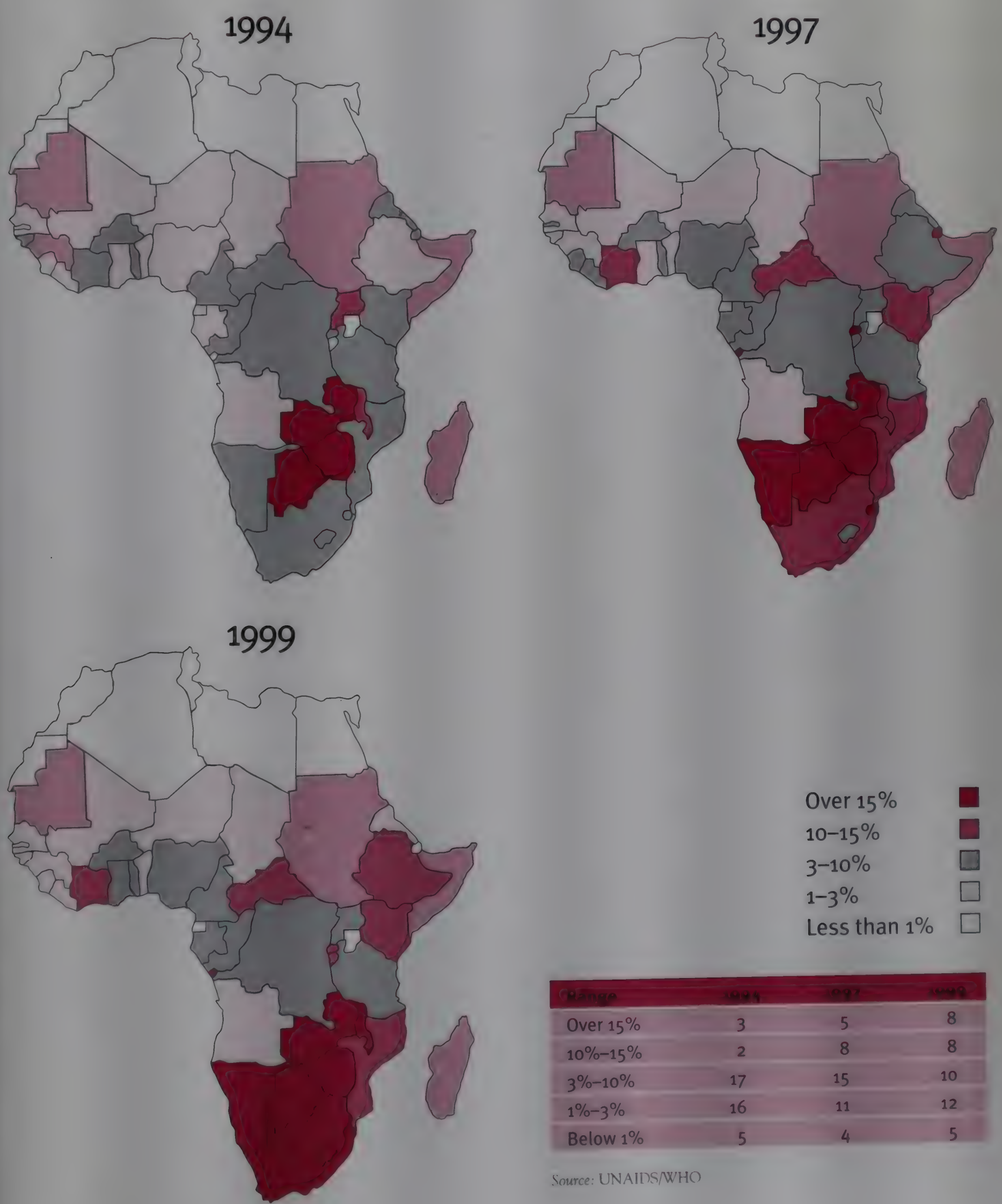
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Annex D: List of acronyms

AIDS	Acquired Immune Deficiency Syndrome	NGO	Non-Governmental Organisation
ARV	Antiretrovirals	PRSP	Poverty Reduction Strategy Paper
CSO	Civil Society Organisation	PLWHA	People Living With HIV or AIDS
DOTs	Directly Observed Treatment	STI	Sexually Transmitted Infection
EC	European Community	SWAP	Sector Wide Approach
FAO	Food and Agriculture Organisation	TB	Tuberculosis
FBO	Faith Based Organisation	UNAIDS	United Nations Joint Programme for HIV/AIDS
HIPC	Heavily Indebted Poor Countries	UNDAF	United Nations Development Assistance Framework
HIV	Human Immunodeficiency Virus	UNFPA	United Nations Population Fund
IAVI	International AIDS Vaccine Initiative	UNICEF	United Nations Children's Fund
IDT	International Development Target	VCT	Voluntary Counselling and Testing
IDU	Injecting Drug Use	WB	World Bank
IPAA	International Partnership against AIDS in Africa	WHO	World Health Organization
MAP	Multi-Country AIDS Programme		
MTCT	Mother to Child Transmission		

Annex E: HIV prevalence among adult population (15–49 years) in sub-Saharan Africa





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